Mr. Raef Faris Msc. FRCOG
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SW1W 8RH

Honorary Consultant Gynaecologist
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For administrative use only.

Hospital No: **Registration date:**

PATIENT HISTORY FORM

1. REGISTRATION DETAILS

First Name …… Date of Birth ……

Surname …… Age ……

Occupation …… NHS No ……

Who referred you to the Lister? □ Consultant Name……

□ GP Name……

□ Self-referral

Address for Correspondence
The Lister Hospital, Chelsea Bridge Rd, Chelsea, SW1W 8RH
Tel (Switchboard) +(44) 02077307733
Secretary +(44) 02078814038
Appointments +(44) 02077308298
Fax +(44) 02072599039
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2. GYNAECOLOGICAL HISTORY

Have you had a history of vaginal discharge requiring treatment by a doctor, excluding thrush? Yes No

Have you had a history of any sexually transmitted infections (chlamydia, syphilis, gonorrhoea, genital herpes or genital warts)? Yes No

Have you had a history of pelvic inflammatory disease? Yes No

When was your last cervical smear? ……

Was it normal? Yes No

Have you ever had an abnormal smear? Yes No

(If yes, please provide details: repeat smear colposcopy, cone biopsy or laser treatment)

……

……

3. MENSTRUAL HISTORY

How old were you when your period started? …… years

Are your periods regular? Yes No

How many days do you bleed for? …… days

If your periods are regular, how many days are there usually between the first day of one period and the first day of the next? …… days

If your periods are not regular, what are the shortest and longest times between periods in the last 12 months? Between …… and …… days

When did your last period start? ……/……/……

Are your periods painful? Yes No

Do you bleed between periods? Yes No

Do you bleed during or after sexual intercourse? Yes No

Do you experience pain during intercourse? Yes No

Do your breasts ever secrete fluid? Yes No

Do you have a problem with body hair? Yes No

Have you started your menopause? Yes No

If you have started your menopause, which year did it start? ……

Do you take hormone replacement therapy (HRT)? Yes No

If you are on HRT, when did you start taking it? ……

What form of HRT do you take? ……

4. PREVIOUS CONTRACEPTION

Please tick if you have used one of the following contraceptive methods:

	Year	Problems, if any
□ Contraceptive Pill (Please state brand)	……	……
□ IUCD (coil)	……	……
□ Intra-muscular injections	……	……
□ Condom / cap	……	……

What was your last blood pressure reading? ……

Are you being treated for high blood pressure? Yes No

(If yes, what medication are you currently taking?)

……

……

Have you ever had a cardiac / circulatory problem? Yes No

Do you suffer from migraines? Yes No

Do you have a history of blood clotting disorders such as

Pulmonary Embolus (PE) or Deep Venous Thrombosis (DVT)?	Yes	No
Are you diabetic?	Yes	No
If you are diabetic, is your diabetes well controlled on medication?	Yes	No
Have you been diagnosed with liver problems / gall stones?	Yes	No
Do you have Systemic Lupus Erythematosus (SLE) or Antiphospholipid Syndrome (APS)?	Yes	No
Do you suffer from porphyria?	Yes	No
Have you ever been diagnosed with cancer of the breast?	Yes	No
Have you ever been diagnosed with cancer of the uterus (womb)?	Yes	No
Do you smoke?	Yes	No

5. PREVIOUS SURGICAL HISTORY

Please tick if you have had any of the following:

□ Removal of right ovary	□	Removal of left ovary
□ Ovarian drilling for PCO	□	Removal of ovarian cyst
□ Laparoscopy	□	Tubal surgery
□ Surgery on cervix	□	Appendectomy
□ Separation of adhesions	□	Removal of fibroids (myomectomy)
□ Sterilisation	□	Reversal of sterilisation

□ Other abdominal or pelvic operations (If yes, please provide details)

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……

6. PREVIOUS MEDICAL HISTORY

Please tick if you have had any of the following:

□	Rheumatic fever	□	Radiotherapy
□	TB	□	Chemotherapy
□	Diabetes	□	Thyroid
□	Jaundice	□	Asthma
□	Hypertension (high blood pressure)	□	Myocardial infarction
□	CVA (stroke)	□	Epilepsy
□	Sickle cell anaemia or trait	□	Thalassaemia

Have you had any hospital admissions for any other illnesses? Yes No

Have you had any problems with anaesthetic in the past? Yes No

(If yes, please provide details)

……

Do you have any inherited conditions? Yes No

(If yes, please provide details)

……

Do you have any other relevant family history? Yes No

(If yes, please provide details, particularly for any history of breast

or gynaecological cancer on your mother's side of the family)

……

Are you on any long-term medication? Yes No

(If yes, please provide details)

……

……

Do you have any allergies? Yes No

(If yes, please provide details)

……

7. PREVIOUS PREGNANCIES

Year and outcome of any pregnancies

Year	**Outcome *** (Live birth / miscarriage / ectopic / termination	**Mode of Conception** (Natural / IVF / Donor etc)

** Please state any complications which occurred during or after pregnancy*

8. GENERAL HEALTH

What is your height? ……

What is your weight? ……

Is your weight… Steady / increasing / decreasing?

Do you smoke? Yes No

If yes, how many cigarettes …… per day?

Do you drink? Yes No

If yes, how many units …… per week?

Do you take any recreational drugs (cannabis, cocaine etc)? Yes No

9. Main Complaint (could be left to be discussed with the Doctor)